Northwestern Memorial® Hospital

MRI Pre-Examination Screening Form

Patient Name _____Date of birth _____ Height: _____ Weight_____

Allergies_____

To the best of your ability, please list all your current medications including prescriptions, over-the-counter, eye drops, herbal supplements and vitamins. If more space is needed, please utilize the back of this page.

Medication Name	Dose (include strength and number of units)	How do you take it?	How often do you take it?	When did you last take it?
Ex. Cardizem CD	*180 mg. 1 capsule*	*By mouth*	*Once a day*	*9 pm last night*

	Yes	No
Are you taking the following medication? **Hydroxyurea, also known as Hydrea™, Droxia™ and Mylocel™**		

Please complete the following checklist	Yes	No
Do you have a condition called Nephrogenic Systemic Fibrosis?		
Do you have a history of kidney disease?		
Are you currently on dialysis?		
Have you received an organ transplant or are you being considered for a transplant?		
Have you ever had an injury to the eye involving a metallic object or fragment?		
Have you ever been injured by a metallic object (bullet, shrapnel, etc.)?		
Do you have any breathing problems, motion disorder or claustrophobia?		

Do you have any of the following items in or on your body?	Yes	No
Cardiac pacemaker, pacer wires or implanted cardioverter defibrillator (ICD)		
Neurostimulators (brain, spine, bone etc.)		
Brain/aneurysm clip		
Internal electrodes or wires		
Tissue expander (e.g., breast)		
Metallic stent, filter or coil - Please specify type and location:		
Magnetically activated implant or device (e.g., VP shunt)		
Shunt (spinal or intraventricular)		
Eye or ear implant, springs or wires		
Insulin or other infusion pump		
Joint replacement or any type of prosthesis (heart valve, eye, hip, knee etc.)		
Bone or joint pin, screw, nail, wire, plate etc.		
Penile implant / prosthesis		
Hearing aid		
Surgical staples, clips or metallic sutures		
Dental or partial dental plates		
IUD, diaphragm or pessary		
Medication patch (Nicotine, Nitroglycerine)		
Body piercing or tattoos		
Any metallic fragment or foreign body		

I attest the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MRI procedure that I am about to undergo.

Patient/
Guardian Signature _____ Date _____

Staff
Signature _____ Date_____

Form
Completed by: ☐ Patient ☐ Relative ☐ Other

_____
Print Name Relationship to Patient

504066 (07/11)